STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 86985-001**
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 8th day of February 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 3, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it for external review on January 10, 2007.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on January 18, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Comprehensive Health Care Copayment Certificate Series CMM 1000* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner suffers from a condition called idiopathic ventricular tachycardia and frequent premature ventricular contractions (PVC). He was referred by his physician to electrophysiologist, Dr. XXXXX at the XXXXX Medical Center. On February 9, 2007, procedures and studies were provided to the Petitioner by Dr. XXXXX. BCBSM paid $2,520.67 of the $11,623.00 charged. This left the Petitioner to pay the balance of $9,102.33. Dr. XXXXX is a nonparticipating provider, i.e., he has not signed an agreement to accept the BCBSM or local Blue Cross Blue Shield plan's approved amount as payment in full.

The Petitioner appealed the amount BCBSM paid. BCBSM held a managerial-level conference on November 6, 2007, and issued a final adverse determination dated November 8, 2007.

III
ISSUE

Is BCBSM required to pay an additional amount for the care provided the Petitioner by Dr. XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner has struggled for over five years with ventricular tachycardia and frequent PVC's. He had four unsuccessful catheter ablations, three at XXXXX Hospital and one at the XXXXX Hospital. He says he switched his health care coverage from the XXXXX to traditional Blue Cross and Blue Shield in order to have more doctors available to him; the traditional plan is much more costly but he thought it would be better.

The Petitioner says he knew Dr. XXXXX did not participate with BCBSM but went to him only after exhausting his search for help and following the recommendation of his doctor. The Petitioner feels that BCBSM should pay more on his claim because Dr. XXXXX was the only

provider who could meet his needs. He does not think it fair that he is required to pay such a large balance for his care.

BCBSM's Argument

BCBSM says the amounts charged by Dr. XXXXX and the amounts it paid for the Petitioner's February 9, 2007, care are set forth in this table:

Procedure Code	Amount Charged	BCBSM's Maximum Payment Amount	BCBSM's Approved Amount	Amount Paid by BCBSM	Petitioner's Balance
93609	$ 1,500.00	$ 344.78	$ 344.78	$ 344.78	$1,155.22
93620	$ 3,000.00	$ 813.301	$ 813.301	$ 813.30	$ 2,186.70
93621	$ 2,000.00	$ 145.00	$ 145.00	$ 145.00	$ 1,855.00
93652	$ 5,123.00	$ 1,217.59	$ 1,217.59	$ 1,217.59	$3,905.41
Totals	$11,623.00			$2,520.67	$9,102.33

BCBSM says that Section 4 of the certificate, *Coverage for Physician and Other Professional Services,* explains that it pays an "approved amount" for physician and other professional services -- the certificate does not guarantee that charges will be paid in full. BCBSM paid 100% of its approved amount (the maximum payment) for the Petitioner's care. However, since Dr. XXXXX does not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full.

In determining the maximum payment level for each service, BCBSM says it applies a Resource Based Relative Value Scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training, and medical practice. BCBSM says there is nothing in the certificate that requires it to pay any additional amount even if the care was provided for a life-threatening condition or even if there was no participating provider to provide the care.

BCBSM believes that it has paid the correct amount for the Petitioner's care by a nonparticipating provider and is not required to pay any additional amount.

Commissioner's Review

The certificate describes how benefits are paid. It explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." Participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges. The certificate says (on pages 4.22):

> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM paid for the Petitioner's services on February 9, 2007, based on its full approved amounts. It is unfortunate that the Petitioner felt he was in a situation where he did not think he could use a participating doctor. Nevertheless, there is nothing in the terms and conditions of the Petitioner's certificate that requires BCBSM to pay more than its approved amount to a nonparticipating provider even if there was no participating provider able to provide the care.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

BCBSM's final adverse determination of November 8, 2007, is upheld.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham

County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.